



State of California Secretary of State

STATEMENT OF INFORMATION (Limited Liability Company)

39

Filing Fee \$20.00. If amendment, see instructions.

IMPORTANT — READ INSTRUCTIONS BEFORE COMPLETING THIS FORM

1. LIMITED LIABILITY COMPANY NAME (Please do not alter if name is preprinted.)

MEDICYNC LLC

FILED
in the office of the Secretary of State
of the State of California

JAN 28 2010

This Space For Filing Use Only

DUE DATE:

FILE NUMBER AND STATE OR PLACE OF ORGANIZATION

2. SECRETARY OF STATE FILE NUMBER

200925910068

3. STATE OR PLACE OF ORGANIZATION

California

COMPLETE ADDRESSES FOR THE FOLLOWING (Do not abbreviate the name of the city. Items 4 and 5 cannot be P.O. Boxes.)

4. STREET ADDRESS OF PRINCIPAL EXECUTIVE OFFICE

530 Vallejo St.

CITY AND STATE

Half Moon Bay

California

ZIP CODE

94019

5. CALIFORNIA OFFICE WHERE RECORDS ARE MAINTAINED (DOMESTIC ONLY)

530 Vallejo St.

CITY

Half Moon Bay

STATE

CA

ZIP CODE

94019

NAME AND COMPLETE ADDRESS OF THE CHIEF EXECUTIVE OFFICER, IF ANY

6. NAME

ADDRESS

CITY AND STATE

ZIP CODE

NAME AND COMPLETE ADDRESS OF ANY MANAGER OR MANAGERS, OR IF NONE HAVE BEEN APPOINTED OR ELECTED, PROVIDE THE NAME AND ADDRESS OF EACH MEMBER (Attach additional pages, if necessary.)

7. NAME

ADDRESS

CITY AND STATE

ZIP CODE

Darin T. Okuda

530 Vallejo St.

Half Moon Bay

California

94019

8. NAME

ADDRESS

CITY AND STATE

ZIP CODE

9. NAME

ADDRESS

CITY AND STATE

ZIP CODE

AGENT FOR SERVICE OF PROCESS (If the agent is an individual, the agent must reside in California and Item 11 must be completed with a California address. If the agent is a corporation, the agent must have on file with the California Secretary of State a certificate pursuant to Corporations Code section 1505 and Item 11 must be left blank.)

10. NAME OF AGENT FOR SERVICE OF PROCESS

Legalzoom.com, Inc.

C2967349

11. ADDRESS OF AGENT FOR SERVICE OF PROCESS IN CALIFORNIA, IF AN INDIVIDUAL

CITY

STATE

ZIP CODE

CA

TYPE OF BUSINESS

12. DESCRIBE THE TYPE OF BUSINESS OF THE LIMITED LIABILITY COMPANY

Health Care Consulting

13. THE INFORMATION CONTAINED HEREIN IS TRUE AND CORRECT

Barbara Dang

TYPE OR PRINT NAME OF PERSON COMPLETING THE FORM

SIGNATURE

Authorized Rep.

TITLE

01/25/2010

DATE